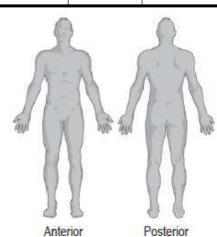
FIRST AID TREATMENT FORM



Date													
Time (24h													
Was Consent Provided Prior To Administration of First Aid YES NO											NO]	
Any injury to staff or volunteers which requires medical assistance you must obtain a FIRST MEDICAL CERTIFICATE													
Patient Gender Patient M F			Given Name			Patient Surname						Αg	e
Patient Address			Patient	ber Alternate			ternate Nur	Number					
Medical His	Medical History; Diabetes, Cardiac, Respiratory, Allergies, Medications, Injuries, Other;												
Last time c	t time consumed food or fluids: Have medications, alcohol or substance								substances	COI	nsum	ed?	
Time		on of Injury and Treatment								Init	ial		
Ambulance Required: Y N Ambulance hand				over time: Advised: Seek Medical Assista						dical Assistance)	Y	N
	LOCATION				MEDICATION/OXYGEN								
Head Neck	Pelvis Leg	Che Abd	st Iomen		Time		Route		Effect	Name		Dose	
Face Foot	Arm Hand	Othe	er										
FOOL													
INJURIES 1. Break 6. Burn 12. Sting/Bite													
 Break Abrasions 	6. Burn 12. 7. Swelling 13.		Assault										
Puncture Penetration	8. Sprain/Strain 14. Co		Cut Pre Existing										
5. Intoxication			16. Other										

Draw freehand where the injury occurred on premise, include any equipment used- chair, play equipment



FIRST AID TREATMENT FORM



Incident Revision
Incident Recognition
☐ Staff, ☐ Swim Teacher, ☐ Public, ☐ Family, ☐ Other Name: Contact Number:
First Responder
☐ Staff, ☐ Swim Teacher, ☐ Public, ☐ Family, ☐ Other Name: Contact Number:
Incident / Accident Narration:
Staff providing treatment:
Signature:
All Information on the form has been completed in full and correct.
Manager or Equivalent verification aware: DD / MM / YYYY Up chain reporting required?: Actions taken for rectification if required:
Date and signature Manager or Equivalent all actions rectified: